Medicare Prescription Drug Coverage
Personal Information Worksheet

Beginning January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare, regardless of income, health status, or how you pay for your prescriptions today. The plans will provide insurance coverage for brand name and generic prescription drugs. The drug plans may vary in what prescription drugs are covered, how much you have to pay, and which pharmacies you can use. It is important that you choose a plan that meets your needs.

How should I use this worksheet?

Use this worksheet to help gather all the information you need to choose a Medicare drug plan that meets your needs. Please fill out as much of the information in this worksheet as possible. You may find it helpful to gather all your prescription drug containers and your red, white, and blue Medicare card, as well as other health insurance cards you may have before you complete the worksheet.

Name: _____ **Date of Birth:** _____/_____/_____

Social Security Number: _____-_____-_____ **Telephone Number:** (_____) _____-_____

Medicare Claim Number: _____-_____-_____-_____

Part A Effective Date: _____/_____/_____ **Part B Effective Date:** _____/_____/_____
(if applicable)

Address: _____ **County:** _____

City: _____ **State:** _____ **Zip Code:** _____

Do you have a residence in more than just the above-mentioned state? Yes No

- **If yes, which state(s)?** _____

Marital Status: Single Married*

** If you are married, your spouse will need to complete a separate worksheet.*

Is your income less than $14,355 (single), or $19,245 (couple) and your assets/resources less than $10,000 (single) or $20,000 (couple)?

☐ Yes ☐ No ☐ I don't know

- **If so, did you apply for the extra help from the Social Security Administration in paying for your Medicare prescription drug plan costs?**

☐ Yes ☐ No ☐ I don't know

- **If so, what was the response from the Social Security Administration?***

☐ Accepted ☐ Declined ☐ Still pending

** If you received this letter, please keep it with this worksheet. You will need to refer to it for information when you are choosing a prescription drug plan.*

What are my prescription drug coverage options?

You can get Medicare prescription drug coverage in one of two different ways:

1. **Medicare drug plans.** These plans add coverage to the Original Medicare Plan (and some Medicare Cost Plans and Medicare Private Fee-for-Service plans). The Original Medicare Plan is a fee-for-service plan. You can go to any doctor or hospital that accepts Medicare.

2. **Medicare Advantage plans.** These plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Private Fee-for-Service (PFFS) plans. They offer complete Medicare-covered health care, through a single plan, including drug coverage. Most of these plans offer extra benefits and lower co-payments than the Original Medicare Plan. However, you may have to see doctors, or go to hospitals, that belong to the plan.

What type of drug coverage do you currently have?

- ☐ Prescription drug coverage through an employer or union health plan
- ☐ Prescription drug coverage through a Medigap plan (Medicare Supplement Insurance)
- ☐ TRICARE (military retiree benefits, VA benefits (Department of Veteran Affairs), or FEHBP (Federal employee retirement benefits)
- ☐ Prescription drug coverage through a Medicare Advantage (such as an HMO, POS, or PFFS)
- ☐ Other: _____
- ☐ None of the above

Please read this important information

If you are a member of a Medicare Advantage Plan, you may already have a prescription drug benefit that will meet your needs. By joining a new prescription drug plan, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Contact your Medicare Advantage Plan if you have questions.

If you currently have health coverage from an employer or union, joining a new prescription drug plan could change your current coverage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications.

If you currently have VA, TRICARE, or FEHBP coverage, you may not need to sign up for a prescription drug plan. You should contact your benefits administrator before making any changes.

Are you a resident of a long-term care facility, such as a nursing home? Yes No

- **If yes, what is the name of the facility?** _____
- **Address:** _____
- **City:** _____ **State:** _____ **Zip Code:** _____
- **Telephone Number: (_____) _____-_____**

What is the maximum amount you are willing/ able to pay, as a monthly premium, for a Medicare prescription drug plan?*	**How would you like to pay your monthly premium? If you qualify for extra help with your prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose how you want to pay any remaining premium.**
☐ under $20/month ☐ $20 - $40/month ☐ $40 - $60/month ☐ $60 - $80/month ☐ $80 - $100/month ** This is an estimate only and will be used to help compare the different plan options.*	☐ Deduct it from my monthly Social Security Administration benefit check. ☐ Automatically deduct it from my bank account each month. ☐ I want to pay by mail each month.

List the prescription drugs you are currently taking *(please print; use additional pages, if needed)***.**

This information can be found on your prescription containers. If you need assistance, ask your pharmacist. The **correct spelling** of the drug name, the **dosage** and the **frequency** you take each drug, and the **price** you are now paying is relevant information in comparing plans.

Drug Name	Dosage	Taken how often	Price per month

List the name, city, and zip code of the pharmacies you prefer to use *(list up to three)***.**

1. _____

2. _____

3. _____

Please read and sign below

By joining a Medicare prescription drug plan, I acknowledge that the plan/organization I choose will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. The information on this personal information worksheet is correct to the best of my knowledge. I understand that if I intentionally provide false information on the worksheet, I may be disenrolled from a plan.

Signature: _____ Date: _____

By affixing my signature below, I am acknowledging that I am making my enrollment decision freely and voluntarily. While I may have received information from a volunteer counselor, the final decision was made of my own free will and choice. I further understand that the counselor who assisted me is a volunteer and has merely provided me with information to assist me in my decision. I hereby release any and all liability that may possibly be attributable to the volunteer counselor and agree not to pursue any legal action against the counselor for actions taken in their capacity as a volunteer counselor.

Signature: _____ Date: _____

What should I do with my completed worksheet?

Once you complete this worksheet, you can use it to find a Medicare drug plan that meets your needs. You may compare and enroll on your own through the www.medicare.gov website, with the drug plan sponsor directly, or you may receive assistance from:

- **Medicare.** Speak with a customer service representative by calling **1-800-MEDICARE (1-800-633-4227)**.
- **The Nebraska Senior Health Insurance Information Program.** You can meet with a volunteer counselor, or receive free, unbiased information by calling **1-800-234-7119**.

Nebraska Senior Health Insurance Information Program (SHIIP) **1-800-234-7119**	*This publication is for informational purposes only and is available to the public. Neither the SHIIP program nor the Nebraska Department of Insurance endorses any specific company, product or plan of insurance.*